Data Plan for Evaluating Select Health Insurance Access Programs and Policies in Montana

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Prepared for the Montana Department of Public Health & Human Services

Final Report
December 2006

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INTRODUCTION

In 2005, Montana's Department of Public Health and Human Services (DPHHS) received a continuation State Planning Grant (SPG) from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) to further sustain the state's efforts to expand health insurance coverage. With a subset of these funds, DPHHS subcontracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health to conduct several policy research activities between 2005 and 2007 intended to help inform and support the state's SPG Steering Committee and Project Team responsible for carrying out the grant. This report is one component of the work performed by SHADAC as part of the state's continuation grant.

This report identifies existing data sources that may be used to evaluate the success of six health insurance access policies and programs recently (or on the verge of being) implemented by the state of Montana. An evaluation data plan— including example program evaluation questions, example data measures and indicators, and possible data sources— is outlined for each of the initiatives. The goal of this document is to provide a foundation or starting point for evaluating the health access initiatives and to inform the development of a fuller evaluation plan and methodology by the Montana SPG Steering Committee and Project Team to assess whether its access initiatives are meeting their policy goals and objectives.

Six programs, all authorized during Montana's 2005 state legislative session, are the focus of this report. These are:

- Increased Medicaid Asset Limit for Children (House Bill 552),
- Montana's Children's Health Insurance Plan (CHIP) Enrollment Expansion (House Bill 2),
- HIFA Medicaid Redesign Waiver (Senate Bill 110),
- Insure Montana Program (House Bill 667),
- Big Sky Prescription Drug Program (Senate Bill 324), and
- Prescription Drug Plus Discount Program (Senate Bill 324).

This report first describes the evaluation context for and scope of the data plan and briefly summarizes the approach we used to prepare the report. The heart of this document is then dedicated to providing a separate evaluation data plan for each of the six policy changes and programs listed above. This section of the document provides a description of each initiative, reports on existing program requirements and plans for evaluation, and introduces potential data sources for evaluation. Each program-specific evaluation data plan includes an evaluation matrix, outlining example evaluation questions, example measures to address each question, and possible relevant sources of data. Finally, the report ends with a summary and outlines recommendations for next steps.

PURPOSE AND SCOPE OF EVALUATION DATA PLAN

Program evaluation is the "systematic assessment of the operation and/or the outcomes of a program or policy, compared to a set of explicit or implicit standards, as a means of contributing to the improvement of the program or policy" (Weiss, 1988, p. 4) – or as means to deciding whether a program should be continued. There is no single approach to program

evaluation. The most appropriate and realistic method for evaluation ultimately depends on the purpose, audience, timing and intended use of the evaluation, as well as on the resources available to conduct the evaluation.

Evaluations can serve a variety of information needs. Key distinctions in program evaluation concern the focus, timing, and level of information to be collected. The differentiation among input, process, outcome, and impact evaluations refers to whether an evaluation assesses the resources that are being directed to a program, the activities and operations of a program, and/or the effects, results, or ultimate impacts of a program. The distinction between formative and summative evaluations refers to whether an evaluation is intended to provide information during the developmental stages of a program and/or after the program has been completed. Finally, it can be helpful to differentiate between policy-level and program-level evaluations. Whereas the former focuses on producing information to address higher-level policy concerns and questions, the latter is geared toward generating information that may be useful to program managers and staff involved in the every day direction and operation of a program. Depending on the combination of approaches used, data from evaluations can inform different types of decision-making about a program (e.g., whether to make adjustments to the program's approach, deciding whether to continue or abandon the program), document program accountability (e.g., to a funder), and/or promote organizational learning (e.g., by documenting and preserving a program's history or by producing practical information for program staff active in the everyday administration of the program).

As mentioned above, the purpose of this document is to provide the Montana SPG Steering Committee and Project Team with a foundation or starting point for evaluating the six health access initiatives recently authorized in Montana. Specifically, the document is aimed at informing and facilitating the design and development of a fuller evaluation plan and methodology by Montana SPG staff. It is important to highlight that this document is not intended to provide an in-depth evaluation plan for each or any of the access initiatives. Instead, the purpose of this document is to provide a preliminary and broad plan across the multiple initiatives. Our approach is focused on the broader policy goals of the six initiatives and incorporates both process and outcome evaluation questions. Given the recent and pending initiation of the programs considered in this report, the evaluation data plan may serve information needs at both the early (formative) and later (summative) stages of the initiatives.

Evaluation Topics

Health care access, quality, and costs are key health policy concerns (Shi and Singh, 2004). Access to health care may be conceptualized in a number of ways and involves health care system characteristics, population characteristics, features and patterns of utilization, and patient opinions concerning the convenience and availability of the health care they have received (Shi and Singh, 2004). Different definitions of access take into consideration different dimensions of access (e.g., accessibility vs. affordability) and types of access (e.g., potential vs. realized). The six policy initiatives covered in this report are intended to improve individuals' access to adequate health insurance coverage in Montana and therefore speak particularly to one aspect of health care access, the affordability of care for individuals.

The preliminary evaluation data plan presented in this report also focuses on access—that is, program access as opposed to program costs or the quality of care received by program participants. We concentrate on a small set of core evaluation topics that are relevant across all of the six programs (see Table 1). Two of these topics, program demand and enrollment, are process evaluation topics in nature. The other two, the effect of a program on the state's overall insurance rate and the effect of the program on other program demand, speak to outcome and impact aspects of the programs (or program output).

Table 1. Overarching Evaluation Topics

PROCESS	
Demand for Program	What has been the demand for the coverage made available under the program or policy change?
	Relative to all eligible individuals in the state, how strong has the demand been for the initiative?
Program Enrollment	How many individuals have been enrolled in the program?
	How successful has the program or policy change been in enrolling individuals?
OUTCOME	
Insurance Coverage	How successful has the program or policy change been in reducing the uninsurance rate in the state?
Implications for Other State Programs	To what extent has the program or policy change opened space in other state programs?
	To what extent has the initiative had a woodwork effect on other programs?

Evaluation Timing

As mentioned above, this report may serve information needs at both the early (formative) and later (summative) stages of the initiatives. The indicators outlined in this report may be collected once or at multiple times over time to facilitate both the short- and long-term monitoring of the six initiatives. For each of the six programs, we include indicators to capture changes (e.g., in program demand and enrollment, in the state's uninsurance rates) since the initiation of a program revision or new program. Baseline information is essential to assess such change.

As Montana moves forward in its evaluation activities, SPG participants and the DPHHS will face important questions about evaluation purpose and scope. We encourage the state to consider its evaluation needs and priorities and, based on those decisions, tailor and build upon the approach outlined in this document as needed. For example, the state may determine that its evaluation effort should be directed to just a couple of programs or that more detailed information about a program's operations is needed, in which case, more specific process evaluation questions and measures concerning program activities are needed. Alternatively, evaluation staff may decide that only policy-level evaluation information is needed but questions in addition to those included in this report (e.g., concerning costs and quality) are important to incorporate. We hope this document provides a starting point as the state

considers its needs for measuring and monitoring its progress in state health reform. The final section of this report provides general guidance and recommendations for moving forward in the area of evaluation.

EVALUATION DATA PLAN APPROACH

Several sources of information were used to prepare this document. Background information for each of the six programs was obtained from state bills and fiscal notes, legislative reports and notes, publicly available information accessible through program websites, and materials from the Centers for Medicare and Medicaid Services (CMS). Information about the status of the program and about existing data sources was obtained from program status updates provided to the SPG director in Montana by Steering Committee and Project Team members, brief phone interviews by SHADAC with state staff familiar with or involved in the administration of the programs considered in this report (discussed more below), and supplemental program materials (e.g., program applications, enrollment reports and program summaries) provided subsequently by these staff.

SHADAC conducted telephone calls with a total of six state staff during June 2006. The purpose of the phone calls was to inquire about the current schedule for start-up, applications and enrollment for each initiative; the type of information collected from individuals at application/enrollment/re-enrollment; federal, state, and other requirements for program evaluation and monitoring; requirements and plans for collecting and reporting data; as well as available data sources specifically regarding our priority evaluation areas of program demand, enrollment, and impacts on health insurance coverage and other state access programs in Montana. During the phone calls, SHADAC also solicited evaluation ideas and interests of the program staff.

Potential Evaluation Data Sources

The data plans rely heavily on quantitative data and on existing data sources. For the existing data sources that we identify, we provide commentary about their potential availability and feasibility. In some cases, we present new or additional potential sources of data as well. The types of data we focus on include:

- Program applications and application data systems,
- Program enrollment data systems,
- Budget forecast estimates,
- Special program reports,
- Program referral records, and
- National and state survey data.

In the future, SPG and DPHHS staff also may find it helpful to inquire with additional Montana state resources (e.g., state agencies and offices such as the State Auditor's Office and the Office of Research and Policy Analysis in the Legislative Research Division) about the availability of other data useful for evaluation.

PROGRAM-SPECIFIC EVALUATION DATA PLANS

This section of the report provides a separate evaluation data plan for each of the six programs/policy changes reviewed in this report. For each initiative, we first provide a description of the program/policy change. We then report on existing program requirements and plans for evaluation and summarize potential data sources for evaluation. Each program-specific evaluation data includes an evaluation matrix, outlining specific example evaluation questions, example measures to address each question, and possible relevant sources of data.

Increased Medicaid Asset Limit for Children (HB 552)

Description of Initiative

Prior to House Bill 552, Medicaid eligibility for children under the poverty-related coverage groups required that family assets (resources other than income) not exceed $3,000 in value. House Bill 552 authorized Montana's DPHHS to increase the Medicaid asset test from $3,000 to $15,000 in determining Medicaid eligibility for two poverty-related groups of children: those younger than 6 years of age with family incomes at or below 133% of the Federal Poverty Level (FPL) and children aged 6 to 18 years with family incomes at or below 100% FPL. The policy change took effect on July 1, 2006; as of June 2006, Medicaid applications for children have been evaluated for eligibility based on the new asset limit.

The fiscal note prepared by the Governor's Office of Budget and Program Planning (OBPP) forecasted that an additional 3,775 children will be Medicaid eligible during fiscal year 2006-2007 as a result of the policy change, with the majority of new eligible children (as many as 3,000) coming from Montana's CHIP Program. On an ongoing basis, CHIP staff members are now referring current CHIP enrollees to Medicaid if they seem to be both income and resource eligible for Medicaid. New CHIP applicants also are being reviewed for possible Medicaid eligibility in light of the new asset limit.

Formal Evaluation Requirements and Plans

There are no formal requirements for evaluating the change in Medicaid asset limit. DPHHS is monitoring the number of program approvals for the two children's categories. A one-month sample of applications (applications received during October 2006) is being examined to assess the impact of the new asset limit on eligibility.

Possible Evaluation Data Sources

Data sources that could be helpful in evaluating the demand for and effect of the Medicaid asset limit increase include Medicaid applications, the state's Medicaid enrollment data system, administrative data concerning CHIP referrals, and national survey data such as the Current Population Survey. Program staff noted that the state's Medicaid data system is undergoing significant redesign changes and is being replaced with a new system, the Combined Healthcare Information and Medicaid Eligibility System (CHIMES). Current procedures and data systems affiliated with the program are therefore in transition. To the extent possible, evaluation data needs should be considered in these system revisions.

Medicaid Applications: Under the current system, DPHHS maintains a general "Application for Assistance" that is used for many department programs including Temporary Assistance for Needy Families (TANF), food stamps, and Medicaid. The application solicits the following information from all applicants:

- Demographic information (e.g., resident status, sex, marital status, reservation status, household composition),
- Property/account ownership by household members,
- Non-employment-related income (e.g., social security, etc.) by household members,
- Employment status and earnings of household members, and
- Household expenses, including dependent care expenses.

From applicants who are interested in being considered for Medicaid, the application also inquires about the applicant's need for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services as well as the applicant's health insurance status and medical bills and those of other household members.

Currently, monthly reports on the status of the Medicaid program, produced by the Technical Services Division for the Human and Community Services Division, Public Assistance Bureau, both under DPHHS, do not include summary information on applications received or applications deemed eligible (see more below). A separate Medicaid-specific application is anticipated in the future as part of the Medicaid system redesign.

Enrollment Data: Basic Medicaid enrollment data is currently available through "The Economic Assistance Management System," or TEAMS. This system produces overall Medicaid enrollment counts as well as enrollment numbers for specific Medicaid coverage groups (e.g., the two children groups targeted by the asset test change). The system, however, is otherwise limited in the type of data it generates. For example, it does not currently report the number of applications or eligible applications, nor can it distinguish among existing enrollment, re-enrollment and new enrollment cases.

The Technical Services Division under DPHHS issues a TEAMS Medicaid enrollment report to the Human and Community Services Division, Public Assistance Bureau on a monthly basis. If interested in receiving this information, the Montana SPG Steering Committee and Project Team may request and have access to these reports.

As previously mentioned, Montana's Medicaid data system is in the midst of being revamped; more or different enrollment data/reports may be feasible with the anticipated new system, CHIMES.

CHIP Referrals to Medicaid: Montana's CHIP program refers both current CHIP enrollees and new CHIP applicants to Medicaid if these children seem both income and resource eligible for Medicaid. At the minimum, the CHIP program has been monitoring the number of referrals to Medicaid since the change in the Medicaid asset limit and will likely prepare a report on referrals for the legislature. It is not clear, however, whether referrals prior to the start of the revised Medicaid asset limit were documented. Once the pending Legislative report has been

produced, the SPG Steering Committee and Project Team may have access to a copy of the report.

Budget Forecast Estimates: Using estimates from state agencies, OBPP is responsible for finalizing and signing off on fiscal notes in Montana. The fiscal note for the Medicaid asset limit change includes estimates of the number of children who will be eligible for Medicaid as a result of the increase as well as the number of eligible children likely to be referred from the state's CHIP program.

National Survey Data: The *Current Population Survey (CPS)*—specifically, its Annual Social and Economic (ASEC) Supplement—is widely used for estimating annual insurance rates at national and state levels. In recent years, the sample has been increased in each state to improve the precision of health insurance coverage estimates at the state level. For each household selected into the sample, survey data are collected for all household members. Therefore, the survey affords estimates for both adults and children.

The ASEC survey questions capture the health insurance status of all household members for the prior year as well as the source(s) of insurance each household member has. The survey specifically asks about employer-based insurance, private insurance purchased outside of work, Medicare, Medicaid, CHIP, and veterans'/military health benefits. In addition, the CPS collects thorough data for employment-based and non-employment-based sources of income as well as detailed information on each person's employment status.

Although the CPS provides a regular source of state-level data on health insurance coverage and allows for different types of coverage to be assessed (e.g., Medicaid and CHIP, which are most germane here), the data do not come without limitations. A key restriction is that the sample size for Montana is still relatively small (especially for children), thereby limiting the analyses that can be conducted and introducing sampling-related error into the state's estimates. In the 2005 survey, the most recent data available, the number of children and adults in the CPS ASEC sample for Montana was as follows: 178 children aged 0-5 years, 417 children aged 6-17 years, and 1,192 adults aged 18-64 years. These sample sizes become smaller once analyses break out separate demographic groups (e.g., Native Americans), various income levels, and different types of insurance coverage. To limit the sampling error associated with smaller sample sizes, the Census Bureau recommends that states combine three years of CPS data for reporting and monitoring. It is important to note, however, that it is more difficult to detect change in estimates over time with pooled data. Furthermore, pooling adds challenges to precisely monitoring trends before and after the specific start-up timing of a new program or program change. An additional concern is accuracy in the counting of the uninsured population. Compared to health insurance surveys that have been conducted by individual states, the CPS has tended to produce higher state estimates of the uninsured. In the absence of a regular state survey on health insurance coverage, however, the CPS is a useful, cost-effective resource for monitoring general state trends in health insurance coverage among adults and children.

Another relevant limitation to the CPS has to do with the data it affords concerning the financial status of sample members. While the survey collects thorough information about all sources of

income, it does not collect data on other financial resources (i.e., assets). Therefore, children who may fall below or above the new Medicaid resource test may not be directly identified in the data.

The *Behavioral Risk Factor Surveillance System* (BRFSS) survey is another annual national survey used by many states to monitor health insurance coverage at the state level. Unless a state opts to design and include special questions about children (discussed more below), the BRFSS only collects data on adults aged 18 years and older.

Compared to the CPS, the core BRFSS survey captures less detailed information on health insurance coverage and income. With regard to the health insurance coverage questions, the core BRFSS asks a single question (whether the adult has any kind of health insurance), and the manner in which the question is administered does not allow the type of insurance (e.g., Medicaid) to be recorded.

Because the BRFSS sample does not regularly include children, either a special survey module or state-added questions on children would need to be incorporated into future administrations of the Montana BRFSS (or, as was discussed during the July 2006 SPG conference call concerning BRFSS, a call back survey could be administered to a sample of the state's BRFSS sample). However, even if future questions were added, the fact that these questions were not administered before the time of the Medicaid asset test change (July 2006) means that no BRFSS baseline data would be available. This limits the utility of the BRFSS in evaluating the initial impact of the policy change. Nonetheless, augmenting the survey to include child-focused questions would allow the state to monitor children's access over time. (For more information concerning this option, please refer to memos (dated September 21, 2006) that SHADAC prepared under Montana's current SPG continuation grant. These memos address the use of BRFSS to monitor Montana's uninsured, including children.)

State Survey Data: The possibility of future administrations of the 2003 Montana Household Survey was discussed during the September 2006 SPG Steering Committee Meeting. Should this survey be conducted again in the future, it too could be a source of information for estimating the number of children eligible for the new Medicaid asset limit and for monitoring children's insurance coverage over time. Consideration should be given to whether questionnaire additions or revisions would be needed for this purpose.

Evaluation Data Plan

Table 2 outlines evaluation questions for the Medicaid asset limit increase. In the far left column, process evaluation questions concerning program demand and enrollment are listed first, followed by outcome evaluation questions pertaining to the effect of the policy change on the general uninsurance rate for children in the state and on the state's CHIP program. For each evaluation question, example data measures and possible data sources are indicated. Comments concerning the data are noted in the far right column.

Table 2. Evaluation Data Plan: Medicaid Asset Limit

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
PROCESS			
Demand for Program			
What has been the demand for Medicaid since the asset limit increase?	<u>Number of applications received:</u> - # of relevant child applicants[1] since June 1, 2006[2] with assets above the former $3,000 limit	Medicaid applications	As conveyed by program staff, it may be difficult to isolate applications received due specifically to the asset limit increase. Here, our example measures focus on applicants with assets higher than the former limit. However, such applications were likely received prior to the program change. Currently, the capability of application data to be analyzed seems to be limited, and monthly status reports do not include application counts. Improvements to the application system should be considered as part of the system redesign underway.
	<u>Percent of eligible children in the state who have applied:</u> - # of relevant child applicants with increased assets since June 1, 2006 divided by estimated # of children in state who meet new criteria	Medicaid applications Budget forecast estimates CPS BRFSS and MT Household Survey	See comments above concerning application data. The fiscal note for House Bill 552 includes an estimate of the number of eligible children in the state. SPG staff may want to inquire with DPHHS and the Office of Budget and Program Planning to see if an updated estimate could be generated. CPS does not include data on assets so estimation would be crude. State sample size for children is limited; data from multiple years should be pooled. Survey may miscount the number of people who are uninsured. Questionnaire additions/revisions would need to be considered for future administrations of the BRFSS and the MT Household Survey.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
To what extent has the asset limit increase had an effect on the volume of Medicaid applications received for children?	<u>Change in the number of child Medicaid applications:</u> - # of relevant child applicants during June 2006 minus # of relevant child applicants during June 2005 OR during an average month in the past year - # of relevant child applicants during June 2006 divided by # of relevant child applicants during June 2005 OR during an average month in the past year	Medicaid applications	See comments above concerning application data.
What has been the role of CHIP referrals in the demand for Medicaid since the asset limit increase?	<u>Number of CHIP referrals:</u> - # of relevant CHIP referrals with increased assets since June 1, 2006	CHIP administration data or Legislative report	
	<u>Percent of new child applicants who were referred by CHIP:</u> - # of relevant CHIP referrals with increased assets since June 1, 2006 divided by # of all relevant child applicants with increased assets since June 1, 2006	CHIP administration data or Legislative report Medicaid applications	See comments above concerning application data.
	<u>Change in the number of CHIP referrals:</u> - # of relevant CHIP referrals during June 2006 minus # of relevant CHIP referrals during June 2005 OR during an average month in the last year - # of relevant CHIP referrals during June 2006 divided by # of relevant CHIP referrals during June 2005 OR during an average month in last year	CHIP administration data or Legislative report	The availability of past CHIP referral records from either Medicaid and/or CHIP programs needs to be assessed.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
Program Enrollment			
How many children have been enrolled in Medicaid since the asset limit increase?	<u>Number of new enrollees:</u> - # of relevant child enrollees since June 1, 2006 with assets higher than former limit	TEAMS data system	TEAMS reports monthly enrollment and enrollment for certain subsets (e.g., children with higher assets) may be discernible. However, new enrollment vs. existing enrollment may not be easily distinguished. Improvements to the usability of enrollment data should be considered as part of the system redesign underway.
	<u>Percent of eligible children in the state who have enrolled:</u> - # of relevant child enrollees with increased assets since June 1, 2006 divided by # of children in state who meet new criteria	TEAMS data system Budget forecast estimates CPS BRFSS and MT Household Survey	See comments above concerning TEAMS data. See comments above concerning budget forecast estimates and CPS. See comment above concerning BRFSS and MT Household Survey.
How successful has the asset limit increase been in enrolling more children into Medicaid?	<u>Percent of child applicants who have been enrolled:</u> - # of relevant child enrollees with increased assets since June 1, 2006 divided by # of relevant child applicants since June 1, 2006 with assets above former limit	TEAMS data system Medicaid applications	See comments above concerning TEAMS data See comments above concerning application data.
	<u>Change in the rate of enrolled child applicants:</u> - (% of enrolled applicants since June 1, 2006 minus average % of enrolled child applicants in last year) divided by average % of enrolled child applicants in last year	Medicaid applications	See comments above concerning application data.
	<u>Change in overall child enrollment:</u> - # of new relevant child enrollees with increased assets	TEAMS data system	See comments above concerning TEAMS data.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
	- # of new relevant child enrollees with increased assets divided by total # of enrolled children prior to policy change		
How well has enrollment of children with higher assets gone relative to anticipated enrollment?	<u>Percent of anticipated new child enrollees who have enrolled:</u> - # of new relevant child enrollees with increased assets divided by total # of new enrollees estimated for program change	TEAMS data system Budget forecast estimates CPS BRFSS and MT Household Survey	See comments above concerning TEAMS data. See comments above concerning budget forecast estimates and CPS. See comment above concerning BRFSS and MT Household Survey.
What are the primary reasons child applicants have been denied eligibility since the asset limit increase?	<u>Frequency of reasons for ineligibility</u> - % of relevant child applicants denied since program change due to asset level, income, or other reason	Medicaid applications	See comments above concerning application data.
OUTCOME			
Insurance Coverage of Children			
How successful has the asset increase been in reducing the uninsurance rate for children in the state?	<u>New enrollees without prior coverage:</u> - #/% of relevant child enrollees with increased assets without prior insurance coverage	Medicaid applications	See comments above concerning application data.
	<u>Change in uninsurance rate for eligible children in the state:</u> - % of eligible children in state who are uninsured following the asset limit increase minus % of eligible children uninsured before policy change	Budget forecast estimates CPS BRFSS and MT Household Survey	See comments above concerning budget forecast estimates and CPS. There are several timing limitations to the CPS. First, the months of CPS data collection and the start up of the asset limit change do not overlap perfectly. Second, the questionnaire asks about prior year insurance coverage, which means that state staff will have to wait for 2007 survey to get data on insurance coverage in 2006, during

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
	- (% of uninsured eligible children since June 1, 2006 minus % of uninsured eligible children prior to asset income limit) divided by % of uninsured eligible children prior to asset income limit		which the program change took effect. Finally, pooling multiple years of CPS data (as recommended) makes it difficult to assess change over time. See comment above concerning BRFSS and MT Household Survey data.
	<u>Change in state's overall uninsurance rate for children:</u> - % of children in the state who are uninsured after the asset limit increase minus the % of children uninsured before policy change - (% of uninsured children since June 1, 2006 minus % of uninsured children prior to asset income limit) divided by % of uninsured children prior to asset income limit	CPS BRFSS and MT Household Survey	See comments above concerning CPS data. See comment above concerning BRFSS and MT Household Survey data.
Implications for CHIP Program			
To what extent has the Medicaid asset increase opened slots for additional enrollees in the CHIP program?	<u>CHIP beneficiaries referred to Medicaid:</u> - #/% of new Medicaid child enrollees with increased assets who were CHIP beneficiaries	Medicaid applications CHIP administrative data or Legislative report	See comments above concerning application data.
	<u>CHIP applicants referred to Medicaid:</u> - #/% of new Medicaid child enrollees with increased assets who were CHIP applicants	Medicaid applications CHIP administrative data or Legislative report	See comments above concerning application data.

[1]Relevant child applicants refer to children who fall into the two poverty-related categories impacted by the asset increase.

[2]Although the program did not officially begin until July 2006, agency staff began reviewing applications in June 2006.

Montana's Children's Health Insurance Plan (CHIP) Enrollment Expansion (HB 2)

Description of Initiative

Montana's CHIP provides comprehensive health insurance benefits (comparable to the state's state employee health plan) to children younger than 19 years who lack insurance (for at least one month) and have family incomes up to or at 150% FPL (assets are not assessed in eligibility determination). House Bill 2 allocated tobacco tax (I-149), tobacco settlement (I-146), and state general funds to open and expand the enrollment of eligible children into the state's CHIP program beginning July 1, 2005. Prior to this funding change, just under 11,000 children were enrolled in CHIP, and an enrollment cap and waiting list were in place. Since the increase in funding in July of 2005, the CHIP enrollment cap has been eliminated, and all eligible children on the waiting list have been enrolled. As of August 1, 2006, 13,170 children were enrolled in the program.

The goal of the additional funding is to boost CHIP enrollment of eligible children to approximately 13,900. It is anticipated that reaching this enrollment level will take some time given that the change in the Medicaid asset limit (discussed above) will likely result in an estimated 3,000 CHIP enrollees and applicants being directed to Medicaid instead. If and once CHIP reaches its new enrollment target of 13,900 children, the enrollment cap and waiting list will be reinstated.

Note: In an effort to increase enrollment and remove barriers to families, Montana's CHIP also changed the insurance waiting period from three months to one month, and incorporated the updated FPL guidelines in fiscal years 2005 and 2006. CHIP also examined the administrative options available and, effective October 1, 2006, implemented a third party administrative contract which is expected to decrease administrative expense to the program and allow those funds to be used for health care benefits for children.

Formal Evaluation Requirements and Plans

There are no formal requirements for evaluating the CHIP enrollment expansion. An annual report on all CHIP program activities and program changes, however, is required by CMS and due from the state each January. Annual reports from 2001 through 2005 are available on the program's website at www.chip.mt.gov.

Possible Evaluation Data Sources

Several data sources could be tapped as part of an evaluation of the CHIP expansion. Similar to the data sources identified for the Medicaid asset test increase, these sources include program application and enrollment data, CHIP referrals to Medicaid, and national and state survey data. As with the Medicaid data systems, CHIP data systems also are being revised. The 2005 annual report to CMS reported that the program is in the process of developing and implementing an electronic eligibility determination, enrollment, referral and reporting system. Current procedures and data systems affiliated with the program may therefore be in transition. To the extent possible, evaluation data needs should be considered in any future system revisions.

CHIP Applications: DPHHS has a separate application form for its CHIP program. The form is relatively short (5 pages) and available from a number of sources, including the program's website, statewide health care associations and related agencies, Offices of Public Assistance, and tribal areas. An applicant may mail or fax in the completed application to the CHIP office. The application collects information on:

- Household composition and demographics,
- Family assets,
- Care received and paid for by household members for dependent children and incapacitated adult dependents,
- Employment status and income for household members,
- Other income received by household members, and
- Health insurance status of household members.

All CHIP applications are entered into and stored in an electronic data system, the "Kids Insurance Data System," or KIDS. A monthly report is generated based on this data system but the report mostly provides enrollment information (see below). The number of applications received and the number and proportion of applications that are eligible are not standard items for this report, but these data could be generated on an ad hoc basis for the SPG Steering Committee and Project Team.

Enrollment Data: CHIP enrollment data are available through the KIDS system. On a monthly basis, data reports are generated from this system for DPHHS management. These reports present a regular count of program enrollees and provide separate numbers for new enrollees, continuation enrollees, participants who have disenrolled, and, in the past, individuals on the waiting list. If interested in receiving this information, the Montana SPG team may request and have access to these regular reports.

CHIP Referrals to Medicaid: As discussed above, Montana's CHIP program refers both current CHIP enrollees and new CHIP applicants to Medicaid if they appear both income and resource eligible for Medicaid. The CHIP program has been monitoring the number of referrals to Medicaid since the start of the Medicaid asset limit increase and will likely prepare a report for the legislature. Information on CHIP referrals prior to this Medicaid change also is available. Referrals may be useful in assessing one impact of the CHIP enrollment expansion, the extent to which the expansion has led to an increase in Medicaid demand and enrollment.

National Survey Data: *CPS's Annual Social and Economic (ASEC) Supplement* (summarized earlier) provides data that could be used to estimate the number of children who are eligible for CHIP and to monitor the number and percent of children who are insured. The survey's sample and detailed income data allow for children aged 0-19 years within Montana's CHIP income guidelines (<150% FPL) to be estimated. However, as mentioned earlier, important limitations to the CPS are that 1) the sample size for children in Montana is relatively small, which requires data pooling across years and 2) the CPS may miscount the number of people without coverage. Nonetheless, the CPS is a worthwhile data source for general state trends in children's insurance rates. The state's most recent annual (2005) CHIP report to CMS included CPS-

derived uninsurance rates for children under 19 and below 200% FPL. This report presented multiple 3-year averages using data from 1996 through 2004.

For the same reasons mentioned under the Medicaid asset test, Montana's *BRFSS* survey may have limited utility in initially evaluating the CHIP enrollment expansion. The survey does not regularly collect data on children and even if child-focused questions were incorporated into future administrations of the survey, a baseline indicator of pre-expansion insurance and CHIP coverage, would not be available from the survey. Even so, such questions would allow for monitoring over time.

State Survey Data: Future administrations of the 2003 Household Survey could provide data for estimating the number of children eligible for the CHIP Program and for monitoring children's insurance coverage over time. As mentioned earlier, necessary questionnaire additions or revisions should be considered.

Evaluation Data Plan

Table 3 outlines evaluation questions for the CHIP enrollment expansion increase. In the far left column, process evaluation questions concerning program demand and enrollment are outlined. Outcome evaluation questions are also included about the effect of the program on the overall uninsurance rate for children in the state and on the demand for and enrollment in the Medicaid program. For each evaluation question, example data indicators and possible data sources are indicated. Comments concerning the data are noted in the far right column.

Table 3. Evaluation Data Plan: CHIP Expansion Program

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
PROCESS			
Demand for Program			
What has been the demand for CHIP since the expansion?	Number of applications received: - # applicants since July 1, 2005	KIDS data system	Application data are not included in standard DPHHS monthly KIDS enrollment reports but could be available on ad hoc basis.
	Percent of eligible children in the state who have applied: - # of applicants since July 1, 2005 divided by estimated # of children in state who are eligible for CHIP	KIDS data system CPS BRFSS and MT Household Survey	See comment above regarding KIDS application data. Montana's CPS sample size for children is limited, and data from multiple years should be pooled. Survey may miscount the number of people who are uninsured. Questionnaire revisions/additions would need to be considered for future administrations of the BRFSS and the MT Household Survey.
To what extent has the expansion had an effect on the volume of applications received?	Change in the number of CHIP applications: - # of applicants during July 2005 minus # of applicants during June 2004 OR during an average month in prior year - # of applicants during July 2005 divided by # of applicants during July 2004 or during an average month in prior year	KIDS data system	See comment above regarding KIDS application data.
Program Enrollment			
How many children have been enrolled in CHIP since the expansion?	Number of waitlisted children enrolled: - # of children who were waitlisted at the time of expansion (July 1, 2005)	KIDS data system	Standard DPHHS monthly KIDS enrollment reports include waiting list numbers.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
	Number of new children enrolled: - # of children enrolled since July 1, 2005	KIDS data system	Standard DPHHS monthly KIDS enrollment reports provide separate counts for continuation enrollees and new enrollees.
	Percent of eligible children in the state who have enrolled: - # of new enrollees divided by estimated # of children in state who are eligible for CHIP	KIDS data system CPS BRFSS or MT Household Survey	Standard DPHHS monthly KIDS enrollment reports provide separate counts for continuation enrollees and new enrollees. See above comments concerning CPS data. See comment above concerning BRFSS and MT Household Survey.
How successful has the expansion been in enrolling more children into CHIP?	Percent of applicants who have been enrolled: - # of new enrollees divided by # of applicants since July 1, 2005	KIDS data system	See comments above concerning KIDS application and enrollment data.
	Change in overall enrollment: - # of new enrollees since July 1, 2005 - # of new enrollees divided by # of enrollees prior July 1, 2005	KIDS data system	See comment above concerning KIDS enrollment data.
How well has the expanded CHIP enrollment gone compared to estimated enrollment?	Percent of anticipated new enrollees who have enrolled: - # of new enrollees divided by the total # of new enrollees targeted (3,000)	KIDS data system	See comment above concerning KIDS enrollment data.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
OUTCOME			
Insurance Coverage of Children			
How successful has the expansion been in reducing the uninsurance rate for children in the state?	<u>New enrollees without prior coverage:</u> - #/% of new enrollees without prior insurance coverage	KIDS data system	See comments above concerning KIDS application and enrollment data. 2005 annual report states that "no data is available regarding children having health insurance at the time of application. Determining this figure is a priority during 2006."
	<u>Change in uninsurance rate for eligible children in the state:</u> - % of eligible children in state who are uninsured after CHIP expansion minus the % of eligible children uninsured before expansion - (% of uninsured eligible children since July 1, 2005 minus % of uninsured eligible children prior to expansion) divided by % of uninsured eligible children prior to expansion	CPS BRFSS or MT Household Survey	There are a couple of timing limitations to the CPS. First, the months of CPS data collection and the start up of the CHIP expansion do not overlap perfectly. Also, pooling multiple years of CPS data (as recommended) makes it difficult to accurately assess change over time. See comment above concerning BRFSS and MT Household Survey. The percent of children ≤150% FPL who are uninsured is one performance indicator included in the program's annual report to CMS.
	<u>Change in state's overall uninsurance rate for children:</u> - % of children in state who are uninsured after CHIP expansion minus the % of children uninsured before expansion	CPS BRFSS or MT Household Survey	See comments above concerning CPS data. See comment above concerning BRFSS and MT Household Survey.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
	- (% of uninsured children since July 1, 2005 minus % of uninsured children prior to expansion) divided by % of uninsured children prior to expansion		
Implications for Medicaid Program			
To what extent has the CHIP expansion increased the number of referrals to Medicaid?	<u>Number of CHIP referrals to Medicaid:</u> - # of CHIP referrals to Medicaid since July 1, 2005	CHIP administrative data or Legislative report	Historical information on CHIP referrals to Medicaid is available.
	<u>Change in volume of referrals to Medicaid:</u> - # of referrals during July 2005 minus # of referrals during July 2004 or an average month in prior year - # of referrals during July 2005 divided by # of referrals during July 2004 or during an average month in prior year	CHIP administrative data or Legislative report	See comment above concerning CHIP referral information.

HIFA Medicaid Redesign Waiver (SB 110)

Description of Initiative

The Health Insurance Flexibility and Accountability (HIFA) waiver proposal, which was submitted by DPHHS to CMS in July 2006, seeks to expand Medicaid benefits to selected populations of uninsured Montanans. Senate Bill 110 authorized the DPHHS to pursue the waiver. "At the heart of this proposal is a plan to free up existing state money by using the Medicaid waiver to finance mental health services that are currently state-funded. The plan then reallocates the state's savings to provide Medicaid-funded limited health care benefits to several thousand low-income Montanans who are currently uninsured" (June 2006 final proposal, p. 5). The waiver, which if approved by CMS will take effect in 2007, proposes to use $6.1 million annually in state funds (general fund and tobacco tax revenue) for a match of $15.9 million in additional federal Medicaid funds (Montana gets 69 cents from the federal government for every dollar the state spends on Medicaid services.)

This proposed funding would allow Montana to support in part the state-funded Mental Health Services Plan (MHSP) with Medicaid dollars. MHSP provides mental health and prescription drug benefits to individuals with a severe disabling mental illness but who are not eligible for Medicaid. MHSP beneficiaries deemed eligible for the waiver would receive existing MHSP services as well have the opportunity to enroll in a physical health benefit if they currently do not have health insurance coverage. Up to 1,500 MHSP beneficiaries are anticipated to participate in the waiver program.

The state savings realized by Medicaid's contribution toward MHSP benefits would allow the state to extend health insurance coverage (ranging from premium assistance and limited insurance coverage to a full CHIP-like benefit) to several other uninsured groups in the state. These are uninsured children whose family incomes are ≤150% FPL, former Seriously Emotionally Disturbed (SED) youth aged 18-20 years with incomes ≤150% FPL, and uninsured working parents with incomes ≤200% FPL with Medicaid-eligible children. Up to 1,500, 300, and 600 individuals from each group, respectively, are targeted under the waiver.

Additionally, the waiver proposal seeks partial Medicaid funding for two other existing health care programs: the Montana Comprehensive Health Association premium assistance program (which provides a premium subsidy to participants in the state's high risk pool) and the premium incentive and assistant payments being paid to employers and employees who are participating in the small business purchasing pool under the Insure Montana Program (described in greater detail later).

Formal Evaluation Requirements and Plans

HIFA demonstration waivers approved by CMS will be evaluated by state progress reports and independent evaluations. States must submit progress reports within six months of each demonstration year. According to the CMS website, these semi-annual reports should address:

- The state's uninsured rates,
- The effectiveness of its approach,
- Any effects on employer coverage,
- Other contributing factors, and
- Progress on the state's identified performance measures.

At this time, no formal documents have been put forth by DPHHS specifying plans and a methodology for evaluating the HIFA waiver.

Possible Evaluation Data Sources

Given the status of the waiver proposal, limited information presently exists regarding data sources that are likely to be important and available for evaluation. This is particularly the case in terms of application and enrollment data systems and other program materials. Given that several groups will be targeted under the waiver, it is possible that multiple application/enrollment processes and data systems may be involved. Further, program staff indicated that some beneficiaries may not be identified through a formal application process. For example, SED youth will likely be transitioned off of Medicaid due to age, and some of the working parents to receive benefits may be identified through Insure Montana (described later). Another possible source of information, therefore, will be referrals from other programs. Implementation plans should consider procedures for monitoring these program relationships as well as referrals by the waiver to other programs such as CHIP. Other possible evaluation data sources include forecasted budget estimates (e.g., the number of individuals to be enrolled in the waiver is outlined by target population in the waiver proposal) and national and state survey data (e.g., CPS), which could be used to estimate the number of children eligible for the waiver and to monitor general uninsurance rates in the state over time.

Evaluation Data Plan

Table 4 outlines evaluation questions for the proposed HIFA demonstration waiver. In the far left column, process evaluation questions concerning program demand and enrollment are listed first, followed by outcome evaluation questions on the possible effect of the waiver on the state's uninsurance rate and CHIP program. For each evaluation question, example data indicators and possible data sources are indicated. Comments concerning the data are noted in the far right column.

Table 4. Evaluation Data Plan: HIFA Medicaid Waiver

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
PROCESS			
Demand for Waiver			
What has been the demand for the waiver?	<u>Number of referrals from other programs:</u> - # of referrals from MHSP - # of referrals from Medicaid - # of referrals from Insure Montana	Program administrative data	Processes for identifying intended beneficiaries have not been determined. It is not determined whether and how referrals from other programs will be tracked.
	<u>Number of applications received:</u> - # of applicants since start of program (by target group)	Application data	Application content and data systems have not yet been established.
	<u>Percent of eligible targeted populations who have applied/been referred:</u> - % of MHSP clients who have applied/been referred - % of relevant SED youth who have applied/been referred - % of working adults with Medicaid children who have applied/been referred - # of child applicants divided by estimated # of children in state who meet income eligibility	Program administrative data Application data CPS BRFSS or MT Household Survey	See above comments concerning referrals and application data. Montana's CPS sample size for children is limited and data from multiple years should be pooled. Survey may miscount the number of people who are uninsured. Child questionnaire item revisions need to be considered for future administrations of the BRFSS and MT Household Survey.
Waiver Enrollment			
How many individuals have been enrolled under the waiver?	<u>Number of enrollees:</u> - # of enrollees (by target group)	Enrollment data	Enrollment processes and data systems have not yet been established.
	<u>Percent of eligible targeted populations who have enrolled:</u> - % of MHSP clients who have enrolled	Enrollment data CPS	See comment above concerning referrals and enrollment data. See comment above concerning CPS data.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
	- % of SED youth who have enrolled - % of working adults with Medicaid children who have enrolled - # of child enrollees divided by estimated # of children in state who meet income eligibility	BRFSS or MT Household Survey	See comment above concerning BRFSS and MT Household Survey.
How well has enrollment gone relative to anticipated enrollment?	<u>Percent of anticipated enrollees who have enrolled:</u> - # of enrollees divided by predicted # of enrollees (by target group)	Enrollment data Waiver proposal	See above comment concerning enrollment data. The waiver proposal includes estimates of the number of enrollees under each targeted uninsured group.
OUTCOME			
Insurance Coverage			
How successful has the waiver been in reducing the uninsurance rate in the state?	<u>Change in state's uninsurance rate:</u> - % of children and adults who are uninsured since the waiver implementation minus % of children and adults uninsured before the waiver - (% of uninsured children and adults since the waiver minus % of uninsured children and adults before the waiver) divided by % of uninsured children and adults before the waiver	CPS BRFSS or MT Household Survey	There are several timing limitations to the CPS. First, the months of CPS data collection and the start up of the waiver would not likely overlap perfectly. Second, the questionnaire asks about prior year insurance coverage, which means that state staff will have to wait for the 2008 survey to obtain data on insurance coverage in 2007, should the waiver take effect then. Finally, pooling multiple years of CPS data (as recommended) makes it difficult to assess change over time. See other comments above concerning CPS data as well. Timing issues should be considered as part of future questionnaire revisions to and administrations of the BRFSS or MT Household Survey. See other comment above concerning BRFSS and MT Household Survey as well.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
CHIP Program Implications			
To what extent has the waiver program had a woodwork effect on CHIP?	Number of referrals to CHIP: - # of program applicants who have been referred to CHIP	Program administrative data	Implementation of the waiver should consider procedures for monitoring CHIP referrals.
	Number of new CHIP enrollees: - # of program applicants who have been enrolled in CHIP	Program administrative data	

Insure Montana Program (HB 667)

Description of Initiative

The Montana Small Business Health Care Affordability Act (House Bill 667) authorized the start-up of a health insurance access initiative targeted to small employers and their employees. Funded by a cigarette tax (I-149) and initiated in January 1, 2006, the Insure Montana program provides financial support to small businesses for the provision of health insurance coverage to their employees. Approximately $3 million in overall funding was earmarked for the first year of the program (FY 2006), and $10 million is available for the second year (FY 2007). Beyond fiscal year 2007, continued funding for the program will be determined annually.

The initiative, which is administered by the State Auditor's Office (SAO), is comprised of two components. The first component, for which 40% of the overall program funding is earmarked, provides refundable tax credits to small businesses that already offer one or more health plans to their employees but are at risk of dropping coverage due to concerns about plan affordability. The second component, receiving 60% of program funding, offers a purchasing pool for currently uninsured small businesses. Under the first component, the average annual tax credit amount for employers is just over $5,000. As part of the second component, the purchasing pool, enrolled businesses may choose between two health insurance options offered by Blue Cross Blue Shield (both of which include preventive service, dental, and prescription drug coverage). In addition to access to the pool, enrolled businesses, as well as their participating employees, receive a premium-related benefit. Monthly premium incentives are paid to enrolled employers, and monthly premium assistance payments are directed to eligible employees. The specific premium amount paid to both employer and employee depends on an employee's family income (on a sliding scale basis). The premium incentive for businesses currently averages about $185.00 per month. For employees, the premium assistance averages approximately $143 per month, representing 20-90% of an employee's portion of premium costs. For both components, businesses are enrolled on a first come, first served basis. As of September, approximately 611 businesses (representing 3,219 lives) are receiving tax credits, and about 347 businesses (representing 1,633 lives) are enrolled in the pool. Enrollment will occur annually (October) and will give priority to businesses already participating in the program.

To be eligible for either component of Insure Montana, a business must employ only 2 to 9 employees[1] and no employee within the business, other than the owner, may earn more than $75,000 in annual pay. Additionally, for the tax credits, a business must already provide insurance. For the pool, an employer must not currently provide insurance and must participate in the purchasing pool or another qualified association plan, and employees must meet income and other eligibility criteria. The average income for employees enrolled in the pool ranges from $14,355-$19,140 for single employees and a high of $29,025-$38,700 for married employees with children.

Formal Evaluation Requirements and Plans

There are no formal requirements for evaluating the new Insure Montana program. However, if the state's pending HIFA waiver is submitted and approved, the program will be supported in part by the waiver, and federal requirements for some evaluation may therefore be applicable. A formal audit of

[1] A rule change, which expanded the allowable business size from 2-5 to 2-9 employees, took effect in August 2006.

the program is anticipated by the beginning of 2007. The audit will likely focus on application eligibility requirements (e.g., employee salaries) and monitor that such requirements are met by businesses approved for and enrolled in the program. For the Legislature, the SAO is currently monitoring program progress towards expending the $13 million allocated during the first two years of the program (FYs 2006 and 2007).

Possible Evaluation Data Sources

Data sources that may prove useful in evaluating the Insure Montana program include program applications, monthly enrollment reports, health service claims data, fiscal note estimates, the 2006 re-administration of the Employer Survey on Health Insurance Coverage (conducted by the University of Montana), future state employer surveys, national survey data, as well as surveys of program applicants/enrollees.

Program Applications: The two components of the program require that an interested business complete the same application form, which is available on the program's website. The application collects descriptive and qualifying information from all applicants, including

- Contact information for the business,
- Number of employees,
- Estimated number of eligible employees,
- Number of employees/owners interested in participating,
- Whether any employee earns more $75,000 per year, and
- Whether the business has provided group health insurance in the past two years.

The application then breaks off into two sections, one for each program component. For the insurance pool, the application asks additional questions to determine whether the business would participate in the pool or an association plan; the number of employees, dependent children, and spouses who would be covered; employees' ages, and whether the employer would contribute to premiums for dependents as part of the program. Income and insurance status is collected for all employees who apply to participate in the pool. For the tax credits benefit, the application confirms whether the business currently sponsors a small group health plan, collects information about the specific policy, and solicits the total premium paid per employee per month, the ages of covered employees, whether the plan covers employee spouses or dependents, the amount of the employer contribution, and the ages of those covered.

All applications are to be stored in an electronic format. As of yet, no reports have been generated from this database but it may be a potential source of data in the future. Currently, the application form and process are being revised.

Enrollment Reports: On a monthly basis, the Board of Directors (the oversight entity for the Insure Montana program) and other key stakeholders receive a simple enrollment count via email. The status report includes the number of applicants, eligible applicants, and businesses that have enrolled. The SPG Steering Committee and Project Team may request copies of this report.

Budget Forecast Estimates: The fiscal note for Insure Montana program provides an estimate of the number of individuals who will be eligible for either the purchasing pool or tax credits. Also, other

program documentation provides estimates of the number of enrollees for each program component during the first two years of the program. These estimates will need to be updated given the recent change in business eligibility criteria, which broadened the required number of employees from 2-5 employees to 2-9 employees.

Employer Survey on Health Insurance Coverage in Montana:. Funded by Montana's initial and continuation HRSA SPG grants, this statewide telephone survey of employers was conducted in 2003 and then 2006 by the University of Montana. The primary goal of the survey was to collect information about the availability and status of employer-based health insurance in the state. The first administration of the survey was based on a random sample of businesses from a list of employers covered by unemployment insurance. To ensure that a sufficient number of larger businesses was included in the sample, these firms were sampled with a higher selection probability. In 2006, the sample included businesses in the 2003 sample as well as a supplemental random sample of additional businesses. A total of 486 firms completed the telephone survey in 2006, 71% of which had also participated in the earlier survey.

The Employer Survey instrument captures fairly in-depth information about employer-based health insurance in the state, such as whether a firm offers health insurance, a firm's history of offering insurance, health plan features, employee requirements for coverage eligibility, employer and employee premium amounts, employers' opinions on issues related to health insurance coverage, and whether any employees are uninsured. In 2006, the questionnaire was augmented to include a few items that would facilitate some initial assessment of the Insure Montana program. The new survey questions asked about the general income level of employees (to assess program eligibility), whether a firm had heard of the new program, and how likely a firm would participate in the program.

The timing of the second administration of the survey (early 2006) immediately followed the start up of the Insure Montana program (January 2006). As a result, the number of sampled firms enrolled in or knowledgeable about the program was relatively small, thereby limiting the program-relevant information that can be derived from the survey, including whether the availability of employer-based health insurance has changed since the initiation of the program. The 2006 survey data do allow for, however, an up-to-date estimation of the number of businesses that are likely to be eligible for the program and an assessment of the potential demand for the program based on the initial awareness of and interest in the program among employers in the state.

Other Future State Employer Surveys: Future administrations of a state employer survey (whether it be the University of Montana survey discussed above, the Montana Department of Labor and Industry's Employee Benefit Survey conducted in 2004, or a combination of the two) could be an important source of information for evaluating the Insure Montana program down the road. For example, an additional follow-up employer survey would provide more information on changes in the availability of employer-based health insurance after the start of the program; the businesses that may be eligible for the program; the presence of uninsured individuals employed by small businesses; businesses' awareness of and interest in the Insure Montana program; and the health insurance issues and concerns expressed by employers eligible and/or participating in the program as well as those that are not eligible or that have elected not to participate.

National Survey Data: The *Medical Expenditure Panel Survey- Insurance Component*, or MEPS-IC, is a national data source on employer-based health insurance that could also be helpful in monitoring the availability of health insurance through employers in the state and for estimating the number of businesses who may be eligible for the Insure Montana program. Funded by the Agency for Healthcare Research and Quality (AHRQ) and conducted annually by the U.S. Census Bureau, MEPS-IC is a national survey of private business establishments and government employers. Until recently, MEPS-IC did not regularly support state-level estimates for all states. Since the 2004 survey, its random sample of private sector businesses is now large enough in all states, including Montana, to warrant state-level estimates on an annual basis. Prior to this change, Montana's sample size was not typically sufficient for such estimates. Recent exceptions include 1999, when Montana was rotated in with a larger sample, and 2002, when additional sample was purchased for the state. The new private-sector sample for Montana is 704 establishments, with 520 expected to respond to the survey.

Similar to the University of Montana Employer Survey, the MEPS-IC questionnaire collects fairly in-depth information about employer-based health insurance coverage. The questionnaire includes items such as whether an employer makes available or contributes to the costs of a health plan, the number of plans an employer makes available/contributes to, the employer's history of offering health coverage, number of employees (full-time and part-time) eligible for health insurance, employee requirements for coverage eligibility, health plan characteristics, average employer/employee premium amounts, and whether premium amounts vary by employee characteristics.

There are a few disadvantages to keep in mind about the MEPS-IC as a potential evaluation data source for the Insure Montana program. One limitation is that while the state sample sizes have been improved overall, cell sizes remain small for some indicators. For several key analyses, the sample size is acceptable. For example, the percent of firms that offer health insurance and the percent of employees who are enrolled, by firm size, are easily monitored through the MEPS-IC. But for other detailed analyses, the sample size for Montana may not be large enough to support reliable estimates (e.g., average employee premium amount for all business size categories).

Second, MEPS-IC users must wait until the annual public release of the data (typically each summer) to gain access to the most recent summary data. Data for individual establishments, or micro data, are not disseminated. Instead, only summary data are posted for the public on the MEPS website. (However, federal survey analysts are available to conduct some data runs on an ad hoc basis, and the data on which posted tables/analyses are based may also be accessed at a Census Bureau Research Data Center location.) The delay in data availability combined with the fact that the survey collects insurance information for the prior year hinders the timeliness of the MEPS-IC.

Finally, the firm size categories used within the standard posted tables include fewer than 10, 20-24, 25-99, 100-999, and 1,000 and more employees. Also, some analyses are shown by less than 50 and 50 and more employees. The initial requirement of the Insure Montana program that a business only have 2-5 employees did not correspond well with the standard MEPS-IC firm size categories (the smallest of which is less than 10 employees). This is no longer an issue, however, now that the program has been augmented to include all businesses with 2-9 employees.

On the employee level, the *ASEC supplement to the CPS* (summarized earlier) provides data that could be used to generate a rough estimate of the number and percent of adults/children who may be eligible

for participation in the purchasing pool through an employer and to monitor change in the insurance status of those who are targeted by the program. However, as mentioned earlier, important limitations to the CPS are that the sample size for Montana is relatively small, which requires data pooling across years, and that the CPS may overcount the number of individuals without coverage. Further, while an individual's income and whether an individual works at a small business can be determined using CPS data, Insure Montana's eligibility requirements for businesses (e.g., the maximum salary of all employees) could not be controlled for in capturing CPS respondents who may be eligible for the program.

For similar reasons mentioned under the Medicaid asset test and CHIP enrollment expansion program, *Montana's BRFSS* may not offer sufficient data for evaluating the success of the Insure Montana program due to the survey's limited health insurance, employment, and income questions. Based on its current standard content, the survey does not afford estimates of the number of adults/children who may be eligible for the program.

Applicant/Enrollee Surveys: The SAO intends to do a survey of businesses that applied for Insure Montana, were deemed eligible, but ultimately did not enroll in the program. A key purpose of this survey would be to inform the program on how it can address reasons for nonparticipation among targeted firms. Such data could be used to improve program demand and enrollment.

Evaluation Data Plan

Table 5 outlines evaluation questions for the Insure Montana program. Process and outcome evaluation questions are outlined in the far left column. For each evaluation question, example data indicators and possible data sources are indicated. Comments concerning the data are noted in the far right column.

Table 5. Evaluation Data Plan: Insure Montana

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
PROCESS			
Demand for Program			
How many applications have been received for each component of the program (tax credits and purchasing pool)?	Number of business and employee applications received: - # of applicants since start of program (January 1, 2006)	Program applications	Application data may not yet be available in electronic format, but monthly enrollment report includes application data.
	Percent of eligible businesses/employees in state that have applied: - # of applicants divided by estimated # of businesses/employees in state that meet criteria	Program applications Budget forecast estimates MEPS-IC or 2006 state employer survey CPS	See comment above concerning application data. The fiscal note for HB 667 and other program documentation include an estimate of the number of eligible businesses/employees in the state. SPG staff should inquire with SAO and OBPP for updated estimates that adjust for the recent change in employer eligibility (to 2-9 employees). MEPS-IC may permit a rough estimate of eligible businesses based on employer size. The 2006 University of Montana Employer Survey takes into consideration the maximum employee salary. CPS may permit a rough estimate of eligible employees because business requirements (e.g., salary levels of all employees) can not be controlled for.
Program Enrollment			
How many small businesses/employees have been enrolled in Insure Montana?	Number of enrollees: - # of businesses/employees enrolled	Enrollment status reports	

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
	Percent of eligible businesses/employees in state that have enrolled: - # of enrolled businesses/employees divided by estimated # of businesses/employees in state that meet criteria	Enrollment status reports Budget forecast estimates MEPS-IC or state employer survey CPS	See comments above concerning budget forecast estimates and MEPS-IC, state employer survey, and CPS data.
How successful has the program been in enrolling businesses/employees?	% of applicants that have been enrolled: - # of business/employee enrollees divided by # of applicants since start of program	Enrollment status reports Program applications	See comment above concerning application data.
	Percent of applicants that have been waitlisted: - # of eligible but not enrolled businesses/employees divided by # of applicants since start of program	Enrollment data Program applications	Eventually, all applications are to be stored in electronic format. Whether monthly enrollment reports will include numbers on waitlisted applicants needs to be assessed. See comment above concerning application data.
What are the primary conditions under which businesses/employees have been denied eligibility for the program?	Frequency of reasons for ineligibility: - % of business/employee applicants denied for a particular reason	Program applications	Whether and how eligibility determination information will be monitored needs to be assessed.
To what extent have eligible businesses/employees declined to enroll in the program? Why?	Percent of eligible businesses/employees that have elected not to enroll: - # of eligible applicants that have declined divided by total number of eligible applicants	Program applications Applicant survey	See above comment concerning application data. SAO intends to conduct a survey of businesses that applied for the program, were deemed eligible, but ultimately did not enroll in the program.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
	Frequency of reasons for not enrolling: - #/% of eligible applicants that report a particular reason		
How well has enrollment of businesses/employees gone relative to anticipated enrollment?	Percent of anticipated enrollees who have enrolled: - # of businesses/employees enrolled divided by # of anticipated enrollees	Enrollment status reports Budget forecast estimates	See comments above concerning budget forecast estimates and other program documentation.
OUTCOME			
Insurance Coverage of Small Businesses and Their Employees			
How successful has the program been in reducing the uninsurance rate for residents in the state?	Number of lives insured by businesses enrolled in the program: - # of employees and dependents insured by businesses participating in program	Enrollment status reports Other program documentation	It is not clear whether monthly enrollment status reports include data regarding the lives covered. Brief program descriptions from SAO provide up-to-date information on the number of lives covered.
	Change in uninsurance rate for eligible businesses/employees in the state: - % of eligible businesses/employees that are uninsured after program minus the % of eligible businesses/employees that are uninsured before program	MEPS-IC or state employer survey CPS	See comments above concerning MEPS-IC, state employer survey, and CPS data. Delays in the availability of MEPS-IC and CPS data inhibit the timeliness of the data for a pre/post policy implementation comparison. See more below regarding the CPS.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
	- (% of uninsured eligible businesses/employees after program start-up minus % of uninsured prior to program) divided by % of uninsured businesses/employees prior to program		
	<u>Change in state's overall insurance rate:</u> - % of individuals in the state who are uninsured since program start-up minus the % of individuals uninsured before - (% of uninsured individuals since program start-up minus % of uninsured individuals before program) divided by % of uninsured individuals before program	CPS	There are several limitations to the CPS. First, the months of CPS data collection and the start up of the Insure Montana program do not overlap perfectly. Second, the questionnaire asks about prior year insurance coverage, which means that state staff will have to wait for 2007 survey to get data on insurance coverage in 2006, during which the program change took effect. Third, pooling multiple years of CPS data (as recommended) makes it difficult to assess change over time. Finally, survey may miscount the number of people who are uninsured.
Medicaid/CHIP Program Implications			
To what extent has the purchasing pool had a woodwork effect on Medicaid?	<u>Number of referrals to Medicaid</u>: - # of pool applicants who have been referred to Medicaid	Program administrative data	The extent to which Medicaid referrals are being monitored needs to be assessed.
	<u>Number of new Medicaid enrollees:</u> - # of pool applicants who have been enrolled in Medicaid	Program administrative data	See comment above concerning Medicaid referrals.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
To what extent has the purchasing pool had a woodwork effect on CHIP?	Number of referrals to CHIP: - # of pool applicants who have been referred to CHIP	Program administrative data	The extent to which CHIP referrals are being monitored needs to be assessed.
	Number of new CHIP enrollees: - # of pool applicants who have been enrolled in CHIP	Program administrative data	See comment above concerning CHIP referrals.

Big Sky Prescription Drug Plan (SB 324)

Description of Initiative
Senate Bill 324 created the Big Sky Prescription Drug (Rx) Plan. Effective January 2006, this state program is a wrap-around service for low-income Medicare beneficiaries related to the new federal Medicare prescription drug coverage program (Medicare Part D). Big Sky Rx, funded by tobacco tax revenue (I-149), provides monthly prescription drug premium assistance (up to $33.11) to eligible Medicare beneficiaries in the state who are enrolled in a Medicare prescription drug plan (PDP). Depending on how a beneficiary chooses to be paid, the Big Sky Rx program directs premium payments to the PDP directly or to the beneficiary in the form of a check or an automatic bank account deposit.

To qualify, individuals need to be a resident of the state, be enrolled in Medicare, have an annual family income less than 200% FPL, and not be eligible for Medicaid. Assets are not considered in eligibility determination. To enroll, qualified individuals are required to apply for Social Security Extra Help (for low-income people) if they appear to be eligible for this federal assistance.

Enrollment is taking place on an on-going basis. As of June 2006, the program had received over 4,500 applications and as many as 3,000 beneficiaries were enrolled. Full capacity for the program is anticipated to reach 20,000 enrollees. Enrollment is on an annual basis.

Formal Evaluation Requirements and Plans
While the bill authorizing this program requires that DPHHS prepare a report and recommendations for the Governor and Legislature regarding prescription drug use and needs in the state (due September 2006), there are otherwise no formal requirements for evaluating the Big Sky Rx Program. The program informally tracks demand for the program (in the way of applications and telephone calls received for the program) and will carefully monitor program enrollment especially as it approaches its anticipated maximum level (within 10% of its anticipated enrollment).

Possible Evaluation Data Sources
Information that may be particularly useful for evaluating the Big Sky Rx Program include program applications, program enrollment data, budget forecast estimates, and national and state survey data. Currently, there are no formal data systems in place for the Big Sky Rx program, except for eligibility data. The state contracts with an outside vendor for database programming.

Big Sky Rx Applications: Big Sky Rx applications are available via telephone or on the program website (www.bigskyrx.mt.gov). Applications collect key eligibility information such as family monthly income, annual wages, in-kind support, family assets, Medicare enrollment, and disability/blindness work-related expenses. Information about the applicant's Medicare PDP as well as demographic information, including gender, Montana residency status, American Indian tribe membership, and family size, also are solicited. The number of applications received is manually tracked within a spreadsheet on a routine basis. Telephone calls received from individuals interested in the program are regularly monitored and reported by the program's telephone system. Program staff indicated that these data could be made available to the SPG Steering Committee and Project Team.

Enrollment Data: Program staff also monitor the number of individuals enrolled in the program and provide monthly enrollment counts to an advisory group overseeing the program. The SPG Steering Committee and Project Team may have access to these reports.

Budget Forecast Estimates: The fiscal note for the Big Sky Rx Program provides the number of Medicare beneficiaries in the state who are estimated to be eligible for the Program as well as the anticipated number of total enrollees.

Referrals to Medicaid: It is conceivable that Medicaid-eligible Medicare beneficiaries may be identified as a result of Big Sky Rx Program outreach and intake. The bill states that program outreach and enrollment should be coordinated with services provided under other programs. Whether program staff will be monitoring referrals to Medicaid is not clear. Available program administrative data concerning referrals could be useful in assessing the extent to which the Big Sky Rx program has led to an increase in Medicaid demand and enrollment.

National Survey Data: Because both Medicare coverage and detailed income levels may be captured through the *CPS and its ASEC Supplement*, this national survey could also be used to generate estimates of the number of Medicare beneficiaries in the state who meet the income eligibility requirements for program eligibility over time. However, as with the child sample for Montana, the state's CPS sample size for elderly individuals is relatively small. In 2004, the number of survey participants aged 65 and older was 200; in 2005, this number was 221. Pooling of multiple years worth of data in estimation is recommended.

For similar reasons mentioned already, *Montana's BRFSS* may not offer sufficient data for estimating the number of Medicare beneficiaries who are eligible for the Big Sky Rx program due to the survey's limited health insurance and income questions within its core sections. Potential additions to the survey, however, could make the survey useful for this purpose over time.

State Survey Data: Future administrations of the 2003 Household Survey could provide data for estimating the number of Medicare beneficiaries in the state who are eligible for Big Sky Rx and for addressing other possible evaluation questions for this program over time. As mentioned earlier, appropriate questionnaire additions or revisions would need to be considered.

Evaluation Data Plan

Table 6 outlines evaluation questions for the Big Sky Rx Program. Process evaluation questions concerning program demand and enrollment are listed first. Outcome evaluation questions focus on the amount the program has saved participants in premium costs and whether the program has had a woodwork effect on the Medicaid program. For each evaluation question, example data indicators and possible data sources are indicated. Comments concerning the data are noted in the far right column.

Table 6. Evaluation Data Plan: Big Sky Rx Program

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
PROCESS			
Demand for Program			
What has been the demand for the Big Sky Rx program?	Number of applications received: - # of applicants since January 1, 2006	Program applications	Number of applications are regularly tracked by spreadsheet.
	Percent of eligible Medicare beneficiaries in state who have applied: - # of applicants divided by estimated # of Medicare beneficiaries in state who meet income criteria	Program applications Budget forecast estimates CPS BRFSS or MT Household Survey	See comment above concerning applications. The fiscal note for the program includes an estimate of the number of eligible individuals. SPG staff may want to inquire with DPHHS and OBPP staff to determine if an updated estimate could be generated. Montana's CPS sample size for elderly individuals is small; pooling across multiple years would be necessary. Questionnaire changes need to be considered for future administrations of the BRFSS and MT Household Survey.
Program Enrollment			
How many Medicare beneficiaries have been enrolled in the program?	Number of enrollees: - # of enrollees to date	Enrollment data	Monthly enrollments counts to the program's advisory board provides this information.
	Percent of eligible Medicare beneficiaries in state who have enrolled: - # of enrollees divided by estimated # of Medicare beneficiaries in state who meet income criteria	Enrollment data Budget forecast estimates CPS BRFSS or MT Household Survey	See comment above concerning enrollment data. See comments above concerning CPS and budget forecast data. See comments above concerning BRFSS and MT Household Survey.
How successful has the program been in enrolling participants?	Percent of applicants who have been enrolled: - # of enrollees divided by # of applicants since start of program	Program applications Enrollment data	See comments above concerning application and enrollment data.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
How well has enrollment gone relative to anticipated enrollment?	Percent of anticipated enrollees who have enrolled: - # of enrollees divided by estimated # of total enrollees	Enrollment data Budget forecast estimates	See comments above concerning enrollment data. The fiscal note for the program includes an estimate of the number of likely enrollees.
To what extent has the lack of prescription drug plan prevented qualified individuals from receiving benefit?	Percent of eligible individuals who do not report a PDP: - # of eligible applicants who did not report a PDP divided by # of eligible applicants	Program applications and eligibility	It is not clear whether and where this information may be stored.
OUTCOME			
Prescription Drug Savings for Low-Income Medicare Beneficiaries			
How much in prescription drug costs has the program saved participating Medicare beneficiaries?	Total prescription dollars saved by beneficiaries: - Sum of premium assistance paid out for program beneficiaries during a month or year	Enrollment data	It is not clear whether any summary cost data is incorporated into the monthly enrollment reports or whether enrollee-level cost information is available through other means.
Implications for Medicaid Program			
To what extent has the Big Sky Rx program had a woodwork effect on Medicaid?	Number of referrals to Medicaid: - # of Big Sky program applicants who have been referred to Medicaid	Big Sky administrative data	Whether and how referrals are being tracked need to be assessed.
	Number of Medicaid enrollees referred from Big Sky: - # of Big Sky program applicants who have been enrolled in Medicaid	Big Sky administrative data	Whether and how referrals are being tracked need to be assessed.

Prescription Drug Plus Discount Program (SB 324)

Description of Initiative

Senate Bill 324 also approved the establishment of the Prescription Drug Plus Discount Program. This component of the bill authorized DPHHS to create and monitor a program that provides prescription drugs at a discounted price for state residents with household incomes up to 250% FPL and who lack prescription drug coverage or who have prescription needs beyond their existing drug benefit coverage. The program is initially supported by a state special revenue account, which is funded by pharmaceutical manufacturer rebates and excess dollars from a pharmacy access program (also authorized in SB 324), and must be self-sustaining in terms of its funding over time. Approximately 150,000 residents are predicted to be eligible for the discount prescription drug benefit, with 40% estimated to participate in the program.

The Prescription Drug Plus Discount Program was slated to be phased in after January 2006. However, the design and implementation of the program has not yet been finalized and its start-up has therefore been on hold. Consequently, implementation and management procedures have not all been established. For example, as of July 2006, no formal application form or process had been created for the program.

Formal Evaluation Requirements and Plans

No formal requirements or plans to evaluate this program have been announced as of yet. The Senate Bill authorizing the program states that DPHHS must adopt a plan for administering and managing the program, which may (or may not) include a methodology for evaluation. According to state staff, it is anticipated that a more formal evaluation approach will likely be adopted due to the self-supporting nature of the program and the need to carefully monitor program solvency over time.

Possible Evaluation Data Sources

Given the delay in the design and implementation of the program, limited information presently exists regarding data sources that are likely to be important and available for evaluation, particularly application and enrollment data systems and other program materials. It is anticipated that an application for the program will ultimately be available on the internet at www.rx.mt.gov. Other possible sources include forecasted budget estimates (as presented in the Fiscal Note for the bill) and national and state survey data.

Budget Forecast Estimates: The fiscal note for SB 324 provides the estimated number of state residents to be eligible for the drug discount program as well as its anticipated enrollment rate. As is the case with the other programs included in this report, these data can be used to assess the success of the drug discount program in enrolling its targeted and anticipated population.

Referrals to Medicaid/CHIP: It is conceivable that individuals eligible but not enrolled in Medicaid or CHIP may be identified as a result of outreach and intake for the Prescription Drug Plus Discount Program. Whether program staff will be monitoring referrals to Medicaid and CHIP is not known. Available program administrative data concerning referrals could be useful in assessing the extent to which the program has led to an increase in Medicaid and CHIP demand and enrollment.

National Survey Data: Because both income levels and health insurance coverage may be captured through the *CPS and its ASEC Supplement*, this national survey could also be used to generate estimates of the number of state residents who meet the income eligibility requirements for program eligibility. However, the survey does not ask about prescription drug coverage per se. Therefore, the survey offers limited capability in identifying individuals without or with adequate prescription coverage and monitoring changes in these populations over time. However, identifying individuals at or below 250% FPL lacking health insurance coverage could be one estimate of the state residents who lack prescription drug coverage. Assumptions about the likelihood of adequate prescription drug coverage could also be applied to those with insurance coverage to estimate the percent who need additional help beyond their present coverage.

For similar reasons mentioned for the Big Sky Rx Program, *Montana's BRFSS* may not offer sufficient data for estimating the number of Medicare beneficiaries who are eligible for the Prescription Drug Plus Discount Program due to the survey's limited health insurance and income questions within its core sections. Potential additions to the survey, however, could make the survey useful for this purpose over time.

State Survey Data: Future administrations of the 2003 Household Survey could also provide data for estimating the number of individuals in the state who are eligible for Prescription Drug Plus Discount Program and for addressing other possible evaluation questions for this program over time. As mentioned earlier, appropriate questionnaire additions or revisions would need to be considered.

Evaluation Data Plan

Table 7 outlines evaluation questions for the Prescription Drug Plus Discount Program. In the far left column, process evaluation questions concerning program demand and enrollment are listed first, followed by possible outcome evaluation questions on the effects of the program. For each evaluation question, example data measures and possible data sources are indicated. Comments concerning the data are noted in the far right column.

Table 7. Evaluation Data Plan: Prescription Drug Plus Discount Program

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
PROCESS			
Demand for Program			
What has been the demand for the Discount Drug program?	Number of applications received: - # of applicants since start of program	Program applications	Application content and data system have not been established to date.
	Percent of eligible state residents who have applied: - # of applicants divided by estimated # of residents in state who meet eligibility criteria	Program applications Budget forecast estimates CPS BRFSS or MT Household Survey	See comment above concerning application data. The fiscal note for Senate Bill 324 includes an estimate of the number of people eligible for the program. SPG staff may want to inquire with DPHHS and the OBPP for an updated estimate. CPS does not include data on prescription drug coverage per se, so estimation would be crude. Questionnaire changes need to be considered for future administrations of the BRFSS and MT Household Survey.
Program Enrollment			
How many individuals have been enrolled in the program?	Number of enrollees: - # of enrollees since start of program	Enrollment data	Enrollment data system has not been established to date.
	Percent of eligible state residents who have enrolled: - # of enrollees divided by the estimated # of residents in state who meet eligibility criteria	Enrollment data Budget forecast estimates CPS BRFSS or MT Household Survey	See comment above concerning enrollment data. See comment above concerning fiscal note and CPS data. Questionnaire changes need to be considered for future administrations of the BRFSS and MT Household Survey.
How successful has the program been in enrolling participants?	Percent of applicants who have been enrolled: - # of enrollees divided by # of applicants to date	Program applications Enrollment data	See comments above concerning application and enrollment data.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
How well has enrollment gone relative to anticipated enrollment?	Percent of anticipated enrollees who have enrolled: - # of enrollees divided by estimated # of total enrollees	Enrollment data Budget forecast estimates	See comment above concerning enrollment data. The fiscal note for Senate Bill 324 also includes an estimate of the proportion of eligible people who will participate in the program. SPG staff may want to inquire with DPHHS OBPP for an updated estimate.
OUTCOME			
Prescription Drug Coverage			
How successful has the discount drug program been in improving access to prescription drugs?	Enrollees without prior prescription drug coverage: - #/% of enrollees without any prior prescription drug coverage	Program applications	See comment above concerning application data.
	Enrollees with inadequate prescription drug coverage: - #/% of enrollees with inadequate prior prescription drug coverage	Program applications	See comment above concerning application data.
Implications for Medicaid and CHIP Programs			
To what extent has the discount drug program had a woodwork effect on Medicaid?	Number of referrals to Medicaid: - # of program applicants who have been referred to Medicaid	Program administrative data	The design and implementation of the discount drug program should consider procedures for monitoring Medicaid referrals.
	Number of new Medicaid enrollees: - # of program applicants who have been enrolled in Medicaid	Program administrative data	
To what extent has the discount drug program had a woodwork effect on CHIP?	Number of referrals to CHIP: - # of program applicants who have been referred to CHIP	Program administrative data	The design and implementation of the discount drug program should consider procedures for monitoring CHIP referrals.

Evaluation Question	Example Measure(s)	Possible Data Source(s)	Comments
	Number of new CHIP enrollees: - # of program applicants who have been enrolled in CHIP	Program administrative data	

SUMMARY AND RECOMMENDATIONS

The purpose of this document is to provide the Montana SPG Steering Committee and Project Team with a foundation or starting point for evaluating six initiatives aimed at expanding health insurance coverage in Montana. These programs, all of which were authorized during the 2005 Legislative Session, include the increased Medicaid asset limit for children, CHIP enrollment expansion, HIFA Medicaid Redesign Waiver, Insure Montana program, Big Sky Rx Program, and the Prescription Drug Plus Discount Program. The evaluation data plans provided in this report systematically outline example evaluation questions, example data measures and indicators, and possible data sources for each of the programs and policy changes. This report is intended to inform SPG and DPHHS staff as they proceed with developing an evaluation approach in the future. We envision this report to be one source of input to the multi-level process of designing, planning, and conducting program evaluation.

The evaluation approach presented in this report concentrates on a small set of core evaluation topics that are relevant across all of the six programs. This report does not provide an in-depth evaluation plan for any of the programs. Instead, we identify common, overarching evaluation policy topics related especially to program access and apply the topics across all of the initiatives. Two of the four evaluation topics addressed, program demand and enrollment, refer to program processes. The other two, the effect of a program on the state's overall insurance rate and on other state program demand, speak to outcome and impact aspects of the programs (or program output).

As Montana moves forward in its evaluation activities, SPG participants and the DPHHS will face important questions about evaluation purpose and scope. We encourage the state to consider its evaluation needs and priorities and, based on those decisions, tailor and build upon the approach outlined in this document as needed.

Planning and Designing an Evaluation

As mentioned earlier, there are multiple approaches to program evaluation, based largely on the purpose, target audience, timing, and intended uses of the evaluation. Program evaluations of the initiatives discussed in this report could be conducted in a variety of ways.

While it would be ideal to know everything about a program or initiative, limited resources force decision-makers to prioritize. The next step in making use of this evaluation data document is to establish evaluation priorities and to outline parameters for evaluation. An evaluation approach for a selected program or focus area should be shaped by the information that is needed. Some of the questions that are important to consider as the planning process unfolds include:

- What is the purpose of the evaluation?
- Who is the intended audience for the evaluation results?
- What stakeholders need to be considered?
- What information needs are to be address in the evaluation? Do they pertain to all initiatives or just one or a few?
- What levels and types of information are needed?
- What are the best sources for information? Do relevant data exist? Is access to these data for baseline and ongoing monitoring feasible? How else can data be collected?
- When is the information needed?

Answers to the questions above will help to define the scope of the evaluation process.

Types of Evaluation

Evaluations can be conducted in multiple ways and at multiple points during the evolution of a project. They are often designed to focus on one or more of the following: (a) program inputs, (b) program processes, and (c) program outcomes and impacts.

Input-based evaluation seeks to generate information about the resources that are directed to a program or policy. Example questions for an evaluation focused on collecting this type of information include:

- What are the organizational and management auspices involved in the program?
- What funding is being directed to the program?
- What organizational changes are required to design and implement the program?
- What additional resources (such as building space and office materials) are being used by the program?
- How many and what type of staff members are working on the program? What staff training is required?
- Are there adequate resources to carry out the initiative as intended? What resources are lacking?

Process-based evaluation is intended to develop a greater understanding of how a program or initiative is working. Example questions for this type of evaluation are:

- How are employees trained to carry out the program?
- How is the system set up for intake and service delivery?
- How do clients learn about and access the program?
- What is the nature of the service provided by program staff?
- What is required of clients to go through the program?
- Is the program operating as intended?
- Are changes needed to improve the operation of the program?

And, finally, *outcomes-based evaluation* is designed to identify benefits to clients and evaluate the extent to which those benefits are being rendered. Some questions that may be important under this type of evaluation include:

- What major outcomes are to be achieved?
- What impact on clients is wanted to fulfill the program's intended mission?
- What is the status of progress toward achieving program goals?
- Why is each program activity being carried out?
- Does it make sense to continue pursuing the same goals/objectives or is there a need to revise them?
- What unintended outcomes has the program produced?

Policy vs. Program-Level Evaluation

The focus of the SPG program on increasing access to health insurance coverage provided direction to us in the development of this document. As stated earlier, the information contained in this report emphasizes the issues of program access and access to health insurance. Other evaluation questions may ultimately be important for Montana from a policy-level perspective. For example, it may be important to assess whether a program or policy change improves individuals' access to and use of health care, the quality of health care received by participants, and/or the cost and cost effectiveness of an initiative.

State staff may also desire program-level information about an initiative, such as whether a program is operating on schedule, how well program procedures are working, whether there are important barriers for either program staff or participants, or whether alternative activities would improve program operations.

We encourage Montana's evaluators to consider the type of information that is most important and steer the evaluation plan accordingly. Adjustments to the focus and methodology presented in this report will likely be required as the state's evaluation priorities are further defined.

Program-Specific Evaluation Topics Identified by SPG Participants

Several evaluation ideas were identified during the phone conversations SHADAC conducted with state staff as well as during the September 2006 Steering Committee Meeting held in Helena. These concerned:

- The impact of *all initiatives* in expanding access to native populations;
- The impact of the *HIFA Redesign Waiver* on health care safety net providers and uncompensated care costs in the state,
- The health insurance benefit preferences among new *Waiver* participants;
- Whether and how reinsurance and a wellness program could benefit the *small business purchasing pool* (Insure Montana program);
- The cost effectiveness of and need for cost controls for the *small business purchasing pool* (Insure Montana program);
- The cost effectiveness of *tax credits to small businesses* (Insure Montana program);
- The effect on out-of-pocket costs should the *Big Sky Program* begin paying for deductibles; and
- The extent to which beneficiaries are saving money under the *Discount Drug Program*.

Evaluation Resources

We conclude with a compilation of evaluation resources that may be helpful for SPG staff as the state proceeds with developing and implementing an evaluation of their programs and policies intended to expand health insurance coverage to Montana residents. An initial list of select evaluation web resources and books is provided in Table 8.

Table 8. Select Program Evaluation Resources

Websites	American Evaluation Association http://www.eval.org/
	Government Accountability Office www.gao.gov e.g., several reports on program evaluation, such as Performance Measurement and Evaluation: Definitions and Relationships http://www.gao.gov/new.items/d05739sp.pdf
	Centers for Disease Control Evaluation Working Group http://www.cdc.gov/eval/index.htm
	Evaluation Activities in Organizations http://www.managementhelp.org/evaluatn/evaluatn.htm
	The Evaluation Center at Western Michigan University http://www.wmich.edu/evalctr/
Books and Handbooks	Weiss, C. (1998). *Evaluation*. 2nd Edition. Upper Saddle River, NJ: Prentice Hall.
	Bond, S. and K. Rapp (1997). *Taking Stock: A Practical Guide to Evaluation Your Own Programs.* Chapel Hill, NC: Horizon Research, Inc.
	Frechtling, J., L. Shaw, and C. Katzenmeyer (1997). *User-Friendly Handbook for Mixed Method Evaluations.* Washington, DC: National Science Foundation.

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